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GENERAL NOTICES • ALGEMENE KENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

GENERAL NOTICE 1714 OF 2023

Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001
Tel: 0860 105 350 | Email address: cfcallCentre@labour.gov.za www.labour.gov.za

Corrections to Notice number: 48297

Speech Therapy Annexures

The 5 pages were to be inserted between pages 23 and 24.

SPEECH THERAPY ANNEXURES 2023

ANNEXURE A: FIRST SPEECH THERAPY REPORT

1. AUTHORISATION REQUEST FORM			
Please indicate your request type with an X:			
First speech therapy report		Extension of treatment period required	
Additional treatment sessions required		Amendment to treatment codes required	
INJURED EMPLPOYEE DETAILS			
Surname:			
First Names:			
Identity Number:			
Telephone number:			
Address: Postal code:			
EMPLOYER DETAILS			
Name of Employer:			
Telephone number:			
Date of Injury / Onset of symptoms:			
REFERRING DOCTOR DETAILS			
Referring Doctor:			
Telephone Number: _			
Email address:			
Referring Doctor Practice Number			
Dated referral letter stipulating reason for the referral and referring doctor stamp and signature has been included with this authorisation request:	YES	NO	
SUPPORTING DOCUMENTS ATTACHED TO AUTHORISATION REQUEST ONLY IF CLAIM NOT REGISTERED			
Please indicate attached documents with an X (only attach if necessary):			
WCL2		WCL4		ID	
INJURY / SYMPTOM DETAILS			
ICD 10 Code:			
Diagnosis:			
CURRENT PRESENTATION:			

SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
A. SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
Ensure that the treatment goals are specific and measurable with outcome measurements.	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

B. ANTICIPATED DURATION AND FREQUENCY OF TREATMENT INCLUDE DATES	
Overall expected duration of treatment intervention:	
Overall expected number of treatment sessions:	
Frequency of treatment intervention (daily; bi-daily; weekly etc):	

C. ANTICIPATED CODING FOR ABOVE TREATMENT SESSIONS			
CODE:	QUANTITY	CODE:	QUANTITY

MOTIVATION FOR CHANGE IN AUTHORISATION REQUEST (COMPLETE ONLY IF NOT THE FIRST SPEECH THERAPY / AUDIOLOGY REHABILITATION REPORT)

SERVICE PROVIDER DETAILS	
Name:	
Practice Number:	
Date of initial consultation:	
Date of pre-authorisation request:	
Telephone Number:	
Email address:	
Signature:	

ANNEXURE B: MONTHLY / INTERIM SPEECH THERAPY REHABILITATION REPORT

Speech Therapy / Audiology Rehabilitation Progress/Interim Monthly Report
Compensation for Occupational Injuries and Disease Act

Name and Surname of Employee:	
Identity Number:	**Address:**
	Postal Code:
Name of Employer:	
Address:	
	Postal Code:
Date of Accident:	
1. Date of First Treatment:	**Provider of First Treatment:**
2. Name of Referring Medical Practitioner:	**Date of Referral:**
3. Number of Sessions already delivered:	
4. Progress achieved (including outcome measures eg. Swallowing ability, language ability)	
5. Did the patient undergo surgical procedures in this time? Dates and type of surgery	
6. Number of sessions required:	
7. Treatment plan for proposed treatment sessions:	
. **8. From what date has the employee been fit for his/her normal/ light work? (Please circle where applicable)**	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Practice Number:	
NB: Sppech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	

ANNEXURE C: FINAL SPEECH THERAPY REHABILITATION REPORT

Final Report	
Compensation for Occupational Injuries and Disease Act	
Name and Surname of Employee:	**Address:**
Identity Number:	
Postal Code:	
Name of Employer:	
Address:	
Postal Code:	
Date of Accident:	
Date of First Treatment:	**Provider of First Treatment:**
Name of Referring Medical Practitioner:	**Date of Referral:**
1. Number of Sessions already delivered: ____From_____To_____	
2. Progress achieved (including outcome measures eg. Swallowing ability, language ability):	
3. Did the patient undergo surgical procedures in this time? Dates and type of surgery.	
4. From what date has the employee been fit for his/her normal work?	
5. Is the employee fully rehabilitated/has the employee obtained the highest level of function?	
6. If so, describe in detail any present permanent anatomical effect and/or impairment of function as a result of the accident (e.g. swallowing ability language ability)	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Address:	**Post Code:**
Practice Number:	
NB: Speech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	

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